Summary of Public Comments on the *Roadmap for Strengthening and Sustaining Primary Care*

The Office of Health Strategy (OHS) summarizes below public comments on the draft *Roadmap for Strengthening and Sustaining Primary Care ("Roadmap")*. This summary represents thematically related comments submitted in response to OHS' request for public comments. Public comments submitted to OHS can be viewed here.

Theme of Comments	Summary of Comments	OHS Response
Overall Feedback		
Overall support for the Roadmap	Some commenters expressed their support for the Roadmap. A sample of comments included: ▪ The report is comprehensive and addresses goals to improve affordability, improve the quality of care and support the state's primary care infrastructure. ▪ We are supportive of the Roadmap in order to provide better and more meaningful healthcare to patients, while also creating a positive experience for medical professionals in the front line of care. ▪ We strongly support the need for the State to adopt payment models that bolster the ability of primary care to sustainably engage and embed care coordination personnel and programs that address social, environmental, behavioral, and epigenetic drivers of health. ▪ The Roadmap is an impressive compilation of the best advice of many and can serve as the blueprint for primary care health care transformation. ▪ The Roadmap lays out a strategy, with actionable steps geared toward promoting more effective, efficient, and equitable primary care to better needs the needs of patients and sustain primary care professionals. We applaud OHS and the Primary Care Subgroup for outlining the core	OHS appreciates the many stakeholders who expressed their support for the Roadmap and its intention to strengthen the state's primary care system.

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	primary care practice team functions that focus on patient-centered care delivery and chronic disease management. ▪ We support the Roadmap's focus on strengthening primary care, which we believe is an essential foundation for a high performing health system. We also support the identified core functions, which cover a range of generally accepted capabilities associated with advanced primary care. ▪ It is the opinion of some of our physicians that fee for service reimbursement has not served the needs of primary care providers or our patients. Because the fee for service business model is predicated on patient visit volume, primary care physicians have a difficult time meeting the needs of their patients. A value-based reimbursement model as outlined in this state initiative has the potential to improve patient care, reduce overall healthcare expenditures and promote the wellbeing of the primary care workforce. ▪ More effective team-based care can provide patients with ongoing support between visits, identifying, and resolving issues before they result in avoidable visits the emergency department or hospital admission. The use of health coaches can support lifestyle changes that are effective for chronic condition management, navigators can help patients negotiate a sometimes complex array of healthcare services and supports, and community health workers can identify social, economic, and environmental issues that threaten to defeat patients' best efforts to	

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	manage their recovery. Primary care can be a means to provide enhanced access to timely, integrated behavioral health care. […]All of the above will help address the profound disparities in health and healthcare outcomes that affect so many persons in Connecticut[…]	
Commercial insurer commitment to the Roadmap	Some commenters expressed concerns about Connecticut insurers' participation and willingness to commit sufficient resources to implement the Roadmap, adding that without commercial payer commitment, implementation of the Roadmap will not be possible.	OHS is deeply committed to improving primary care in Connecticut and to the success of the Roadmap for patients and practices. OHS will continue to engage the leaders of Connecticut's commercial insurance plans and collaborate on ways to improve primary care for patients and providers in the state.
Roadmap Strategies		
Opposition to the voluntary prospective payment model	Some commenters expressed opposition to the Roadmap's voluntary prospective payment model. A sample of comments included: ▪ Primary care capitation has proven to be unsuccessful at producing savings or improvements to access quality medical care. ▪ The model is flawed and hasn't worked in other states; CT is not positioned to be successful in capitating primary care. ▪ Primary care capitation would pose a significant risk to Medicaid recipients. ▪ Capitation policy changes would have devastating results for patients with chronic health and mental health problems. ▪ Such a system encourages some providers to underserve patients, especially those with complicated care needs that would cost the provider more than the capitation fee will reimburse. ▪ This approach can only serve to exacerbate already increasing health disparities and lead	OHS is committed to ensuring that the public has accurate and clear information regarding the proposals in the Roadmap, all of which are **voluntary.** OHS is also committed to ensuring patients are protected from any potential harm of these voluntary activities. Commenters that asserted "primary care capitation" models are flawed or have not worked in other states did not offer any literature or evidence to support such assertions. The only evidence to the literature that was cited was a long-term study of CMS' Comprehensive Primary Care (CPC) and CPC+ initiatives that involved nearly 600,000 **Medicare fee-for-service beneficiaries** and concluded that hospitalizations and total ED and outpatient ED visits grew at statistically significant slower rates than for beneficiaries in comparison practices – hospitalizations by year five and ED visits by year three of the demonstration – and that expenditures did not change appreciably. Quality of care was not evaluated in the study.[1] The study concludes that primary care transformation takes time to translate into lower hospitalization rates. The study's authors found that a slower rate of growth of hospitalizations of "3.1% less

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	to deterioration and eventually poorer final outcomes. ▪ Implementing and promoting a capitation rate system will disrupt the relationship citizens have with their primary care physician.	in year 5 and 3.5% less in year 6 ($P < 0.01$) and roughly 2% ($P < 0.1$) slower growth each year in total ED visits during years 3 through 6."[2] The study covered only the first two years of CPC+--CPC+ concluded on 12/31/21--which includes some parameters of advanced primary care similar to that included in the Roadmap, but not all. Such a finding is not inconsistent with the goals of the roadmap and does not indicate that the Roadmap design is flawed. Finally, the study's authors noted that its conclusions may not be generalizable to other primary care models, payers or participants because of its unique set of practices and patients, differing rules of other models and supports. Prospective payment for primary care has been the normative primary care payment model in California for decades and is not viewed there as a failure. It is also a commonly adopted payment model in other regional markets. For example, in New York, Capital District Physicians Health Plan implemented a program over a decade ago and has published evaluation findings demonstrating how its integrated prospective payment model and patient-centered medical program has produced impressive results.[3] In addition, many leading national organizations endorse prospective payment for primary care, including the National Academy of Medicine[4], Centers for Medicare & Medicaid Services[5], Commonwealth Fund[6], Primary Care Collaborative[7], Center for Health Care Strategies[8], and Milbank Memorial Fund[9], and other states[10] support and successfully utilize prospective payment to support primary care transformation, which is the goal of the Roadmap. Among the multiple benefits of prospective payment is the flexibility it gives primary care physicians and practice teams to spend more time with individual patients most in need, address social influencers of health, and develop health equity goals. However, the Primary Care Roadmap **does not** require use of a such a payment model to pursue OHS recognition for enhanced payments.

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		Provider participation in any strategies included in Roadmap is **voluntary**. The Roadmap proposes that certain high-quality primary care functions must be demonstrated in order to become "recognized" and receive enhanced payments, but there is no requirement that providers participate or, as a condition of participation, change the way they are reimbursed. The Roadmap merely proposes that **voluntary** primary care alternative payment models (APMs) beyond fee-for-service (FFS) – not limited to prospective payment or capitation – are continued to be made available to reimburse primary care providers. It should be noted that these types of alternative models can be and are currently in use by commercial carriers in the state, regardless of their inclusion in this Roadmap. Please see section 2.4.4.2 of the Roadmap, which clearly lays out the voluntary nature of payment model options and states practices can still choose to continue receiving FFS payments or enter into other primary care APMs. OHS appreciates concerns expressed by consumer advocates and others that any voluntary models ensure protections against harm for consumers. Roadmap section 2.4.4.1 details the multiple parameters that would be included to ensure patients are not harmed and the models can succeed. Parameters include but are not limited to risk adjustment based on age, patient complexity, and gender; measures and monitoring practices to protect against stinting of care and undesired adverse impact; primary care quality measures including equity-focused measures; data sharing and education; and performance-based enhanced payment. OHS is also undertaking additional consumer engagement to ensure continued input and feedback loop into a final version of the Roadmap and subsequent implementation with practices interested in voluntarily undertaking any Roadmap activities. The Roadmap transformation components align closely with the Medicaid program. OHS collaborated with the Department of Social Services (DSS), the agency with Medicaid oversight, to

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		ensure that the commercial proposals aligned with Medicaid's programs and strategic direction to minimize differences in advanced primary care expectations across payers. However, DSS is undertaking their own independent process to evaluate their primary care systems which is not directed by the Primary Care Roadmap. As this process evolves, DSS will continue close collaboration with OHS to ensure a consistent approach across payers. As part of the Roadmap implementation planning process, OHS plans to develop more detailed implementation guidance and parameters to support the FFS and voluntary prospective payment models, and to include measures and monitoring mechanisms to make sure patients are protected from any potential adverse impacts of a new payment model.
Roadmap implementation operational details	Some commenters requested additional details regarding how to operationalize the Roadmap strategies. These comments were largely in reference to the voluntary prospective payment model and related parameters and to the core practice team functions. A sample of comments included: ▪ Define "embedded" and "onsite" as it relates to the core practice team functions and additional members of the care team, with specific requests for flexibility given workforce challenges. ▪ Define "very small practice" and consider how small practices will implement the core functions, including assessing whether small practices require additional time to demonstrate the core functions. ▪ Define "substantial" as it relates to quality performance incentives in the payment	OHS appreciates and acknowledges the requests for Roadmap implementation operational details and plans to develop more detailed implementation guidance and parameters during the Roadmap implementation planning phase of work. OHS will address these suggestions during implementation planning. Please see Section 4 of the Roadmap for a high-level implementation plan.

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	model parameters. ▪ Provide more detailed guidance on payment parameters that will lead to increased standardization across payers. ▪ Provide more guidance on the procedure codes to include in the prospective payment. ▪ Prioritize monitoring of risk-adjusted payments for adverse impact. ▪ Include planned activities to develop an expanded health equity measure set, and other health equity metrics for adoption to ensure robust benchmarking of health equity in the delivery of primary care. ▪ Incentivize and monitor community-clinical collaborations.	
Community-based services to address health needs	Some commenters suggested the Roadmap promotes a corporate medical model to provide social and behavioral health services.	OHS will clarify in the core function expectations of primary care practice teams the linkage to community-based resources, which includes community-based organizations that provide such services through community and clinical integration.
OHS primary care recognition process	Some commenters suggested that OHS' primary care recognition process will "water down" national accreditation standards for PCMH medical homes.	The primary care recognition process described in the Roadmap has no impact on national recognition standards for PCMH. It recognizes those primary care practices in the state that have invested significant time and resources to achieve national PCMH recognition. The roadmap includes some specific steps beyond that recognition for such practices to ensure additional expectations regarding continued embedded care management, care coordination and behavioral health functionality. See Roadmap Section 2.4.3.
Monitoring and evaluation mechanisms	Some commenters suggested increased monitoring mechanisms for measuring access, quality and equity, and ensuring patient feedback in the monitoring system.	OHS will revise the Roadmap implementation plan to incorporate direct engagement with patients through an OHS consumer advisory group and other forums to capture patient experiences with the OHS primary care program and to ensure a thorough focus on equity. The Roadmap currently includes parameters for monitoring

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		against stinting of care and other unintended adverse impacts–see section 2.4.4.1--and OHS will further develop the details of an implementation monitoring and evaluation plan including measurement of access, quality, and equity during implementation planning that includes consumer input and feedback.
Health information exchange/technology	Some commenters requested clarification on the state's efforts to integrate and optimize electronic health records and how the state's health information exchange will support the Roadmap strategies to give primary care practices access to the data they need when they need it.	OHS has shared these public comments with its Health Information Technology Officer and the Director of Connecticut's Health Information Exchange ("Connie") for review and assessment. OHS and Connie are committed to ensuring data availability for primary care practices consistent with HIPAA and Connie's data sharing and consent policies. In addition, OHS will update the "Barriers" section of the Roadmap to acknowledge these discussions and collaboration.
Primary Care Workforce		
Primary care workforce strategy	Some commenters expressed concern that the Roadmap did not include a strategy for addressing primary care workforce shortages in Connecticut, recognizing a robust pipeline of primary care professionals is essential for Roadmap success. Several commenters also offered strategies to develop and retain the primary care workforce such as loan repayment and forgiveness programs, compacts that would encourage healthcare workers to come to the state, and removing barriers for APRNs to enter primary care.	OHS has been communicating with multiple state agencies, such as DPH and Governor Lamont's Office of Workforce Strategy, to address primary care workforce shortages. OHS will review and incorporate statewide initiatives addressing the primary care workforce in the finalized version of the Roadmap. OHS is committed to ensuring high-quality primary care to Connecticut's patients with the support of providers and will continue to engage with them to further the initiative.
Public Comment and Feedback		
Consumer engagement	Some commenters suggested the process to develop the Roadmap was driven by primary care physician groups and lacked sufficient consumer input. Commenters encouraged OHS to take further steps to obtain additional consumer input.	OHS affirms that consumers and patients are a critical source of input and feedback to ensure the Roadmap's success. OHS will revise the Roadmap implementation plan to even more explicitly incorporate consumer engagement. OHS will continue to engage in a robust manner with all stakeholders, and specifically with consumers and patients. In order to further engage patients, OHS has initiated an intensive

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		community outreach effort to hear from patients and consumers about the Primary Care Roadmap components. In collaboration with OHS' Consumer Advisory Council and with the assistance of a new consumer engagement vendor, OHS is conducting listening sessions with communities across the state to ensure their voices are incorporated into the design and implementation of any primary care transformation activities. OHS is engaging trusted community members as partners in outreach and has secured grant funding to compensate for participation in the sessions. OHS is committed to not only seek input on this initiative, but also ensure a consistent feedback loop so that community members are actively contributing to its formation.
Primary Care Investment		
Opposition to primary care investment	Some commenters expressed concern that an increase in primary care spending will be costly and be financed by spending cuts elsewhere on the health care continuum.	To both increase investments in primary care spending as a share of total medical expenditures and reduce overall health care spending growth, a redistribution of spending growth from other health care sectors, including hospitals, pharmacy and specialists, to primary care must occur. There is no necessity for spending cuts, however. These two initiatives – the cost growth benchmark and primary care spending target - work hand-in-hand to increase primary care investment, while slowing health care cost growth. There are many ways to slow the rate of healthcare cost growth that do not impede access for patients with complex conditions or jeopardize increased investments in behavioral health.[11] The transparency afforded by the publicly reported performance on the benchmark is intended to shine light on health care cost growth drivers and facilitate the implementation of cost mitigation strategies. The primary care spending target is just that. It is a target that gradually increases over time to 10 per cent by 2025 and aims to incentivize insurers and provider entities when investing resources to prioritize and support primary care. In and of itself, the primary care spending target does not propose to add any additional money to the system – but encourages primary care spending to increase as a proportion of total costs as health care costs grow.

[1] Fu, N., Singh, P., Dale, S. et al. Long-Term Effects of the Comprehensive Primary Care Model on Health Care Spending and Utilization. J GEN INTERN MED (2021). https://doi.org/10.1007/s11606-021-06952-w

[2] Ibid.

[3] http://www.ehcca.com/presentations/medhomesummit6/wood_ms2.pdf

[4] National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

[5] https://innovation.cms.gov/innovation-models/primary-care-first-model-options

[6] https://www.commonwealthfund.org/blog/2021/strengthening-primary-health-care-importance-payment-reform?utm_source=alert&utm_medium=email&utm_campaign=Improving+Health+Care+Quality

[7] https://www.pcpcc.org/topic-page/payment-reform

[8] Houston, Rob, Brykman, Kelsey. "They're Not Just "Little Adults" — Value-Based Payment Models that Include Children Must Focus on Their Needs. Center for Health Care Strategies, November 2021. https://www.chcs.org/theyre-not-just-little-adults-value-based-payment-models-that-include-children-must-focus-on-their-needs/

[9] https://www.milbank.org/2021/05/primary-care-payment-reform-go-hybrid/

[10] For example, Rhode Island, Colorado, and Washington.

[11] OHS' Technical Team and Stakeholder Advisory Board have recommendations included in the Unintended Adverse Consequences Measurement Plan that will measure unintended adverse consequences of these types of initiatives. This strategy includes tracking preventive care and access measures, similar to the Department of Social Services' PCMH+ Under-Service Utilization Monitoring Strategy, to inappropriate reduction of access to healthcare services, especially for marginalized populations, and insurers transferring costs to consumers to suppress utilization and spending.